Suzanne Stinson

Field Level of Effort: 4 weeks

1. Collect and organize cost and inventory data which are specific to Afghanistan:

   a) demographic data: historic and anticipated population and distribution
   b) geographic data
   c) current consumption patterns and costs of primary health care services
   d) costs and utilization of cross-border and refugee programs

2. Prepare an inventory of existing primary health care facilities and health care personnel in Afghanistan.

3. Prepare an analytical paper on primary health care.

4. Prepare a draft report of the consultancy before leaving Pakistan.

Steve Solter

Field Level of Effort: 1 - 2 weeks

1. Collect and organize cost and inventory data which are specific to Afghanistan:

    a) epidemiological data
    b) vertical program data

2. Prepare an inventory of existing vertical programs in Afghanistan.

3. Prepare an analytical paper on vertical programs.

4. Prepare a draft report of the consultancy before leaving Pakistan.

Dick Blakney

Field Level of Effort: 3 - 4 weeks

1. Collect and analyze cost and inventory data on hospital systems.

2. Devise recurrent cost estimates and projections for a range of hospital bedsize levels, including secondary and tertiary care facilities.

3. Prepare an inventory of existing hospital facilities in Afghanistan.

4. Prepare an analytical paper on hospitals.

5. Outline alternative pharmaceutical requirements in hospital and PHC sector based on average cost of drugs per average standard treatment regimen.

VI. INPUTS REQUIRED

It is anticipated that the following level of effort will be required to carry out Phase I activities.

Field Work Level of Effort: 10 weeks
Hospital Planner: 3-4 weeks
Financial Analyst: 4 weeks
PHC Planner: 1-2 weeks

Total Level of Effort for Phase I: 14 weeks

PLANNING SUSTAINABLE HEALTH SERVICES IN AFGHANISTAN

I. INTRODUCTION

Although no one knows what conditions will prevail in Afghanistan now that the Soviets have withdrawn, it is essential that the Afghans and the donor community begin to plan now for a sustainable health services system that can provide basic health and appropriate hospital services for the great majority of the population, be they returning refugees, internally displaced persons, or Afghans who have remained in their towns and villages throughout the war. In this paper, MSH will describe a medium-term strategy for beginning the planning of such a system and the roles various interested parties might play. At this time, the goal of this process is:

GOAL

> To develop regional health plans for Afghanistan that meet the basic demands and needs of the Afghan population and will be managerially and financially sustainable over the long term.

Our approach is based on several principles which, we feel, should not be overlooked or shunted aside in the desire to provide assistance quickly. These are highlighted below.

PRINCIPLES

1. The Afghan Health System must be sustainable in the long run.

   It is vitally important that multilateral and bilateral donor and Non-Government Organization (NGO) funds be used wisely over the next five years, since it is likely that after this period donor assistance will gradually decrease to prewar levels (in real, inflation-adjusted terms) and Afghanistan will likely have a modest Gross National Product and hence quite modest funds for health expenditures. If this were to happen, we must be certain that the health programs and facilities which we establish now will not turn out to be so expensive or complex that Afghans, both in a future Afghan government and in the private sector, will be unable to afford or manage them. This means that resource allocation decisions now must be based on an understanding of the long-term recurrent cost implications of different kinds of investments in health services and programs and the decisions should promote improved effectiveness and efficiency in service delivery. For example, public hospitals built today will have to be staffed, supplied, and maintained ten-twenty-etc. years from now when Afghan Ministry of Public Health budgets may be extremely small.

2. <u>The Afghan Health System should be equitable.</u>

The future Afghan health system should try to equalize access to and quality of services across the country while realizing the demographic and physical constraints that make this difficult. Health services established in rural Afghanistan since 1980 have been concentrated in those provinces bordering Pakistan rather than being distributed equitably throughout the country. Certain areas, such as the Hazarajat, have very few hospitals, clinics or basic health workers providing primary health care. Other areas, such as Logar province near Kabul, are overloaded with health facilities. In addition, more than 3,000 Afghan refugees have received training in Pakistan; most of these will return to the same border provinces where the bulk of donor resources have already gone. Afghans, donors, and NGOs should direct funds on a population basis rather than on a political basis. For example, funds could be set aside for underserved regions (such as the Hazarajat) until such time as proposals or plans are submitted from these regions which meet the criteria of the funding agencies.

3. <u>Afghans must play a key role in decision-making from the beginning.</u>

Afghanistan belongs to the Afghans and they should govern it. In the health sector, it is crucial for donor agencies, NGOs, and other helping institutions to put Afghan organizations in charge of health services development, in deciding which donors and helping organizations they wish to work with, and in determining resource allocation priorities. Afghans should not merely be employed to carry out the decisions of foreigners. How this can work in practice is difficult, but the principle of decisive Afghan involvement in decision-making from the beginning is crucial if the Afghans are going to manage their own health system in the future.

4. <u>Build on existing strengths and maintain flexibility for now.</u>

A health infrastructure already exists in much of rural Afghanistan and a Ministry of Public Health exists in Kabul. These need to be built upon. In some regions, (particularly in the northeast and northwest), area-based health systems have been established, covering three or four provinces. Every effort should be made by donors to encourage and strengthen such regional systems until such a time that a viable ministry of health with a countrywide mandate has been established in Kabul. To build a viable Ministry of Public Health, the country will need to use some of the existing technical and bureaucratic personnel and systems to rebuild the country. In the short run, a flexible approach is required.

II. MEDIUM-TERM STRATEGY FOR HEALTH SECTOR PLANNING FOR AFGHANISTAN

MSH is proposing that a major effort be made over the next year to begin the planning for the development of Afghanistan's health system. While planning is an iterative process and will need to adapt to the evolving political situation, we feel that a great deal of initial work can be done now to set development on the "right" track according to the principles discussed above. This work can be conducted in three phases. These phases are as follows:

PHASE I: DATA GATHERING AND DEVELOPMENT OF A FRAMEWORK FOR DECISION-MAKING IN THE HEALTH SECTOR (2-3 months)

The objective of this phase is collect data and develop a framework for decision-making in the health sector as a prelude to the subsequent phases. This will require data-gathering in Pakistan on demographic issues, epidemiology of diseases, current consumption patterns for services, inventory of existing health facilities in Afghanistan, and costs of cross-border and refugee programs. It will also include a review of comparative costs from both the prewar period and the current Kabul government to determine reasonable unit costs of various service delivery systems such as community-based, clinic-based, and hospital-based services, and vertical programs. This phase will also require the development of a computer-based spreadsheet model that incorporates planning and costing data that can serve as a framework for decision-making regarding resource allocation in health. As part of this phase, for discussion purposes in Phase II, three to five alternative scenarios for both basic health services and appropriate hospital systems will be developed that meet the principles discussed above. For example, one option might be to focus on primary health care through the delivery of health services in rural clinics and hospitals, supplemented by "vertical" disease control programs such as immunization and malaria control. Another option might be to focus instead on training, supervising and supporting basic health workers and TBAs at the village level, with fewer clinics and hospitals than in the first option. An effective planning process will suggest which segments of the population will receive the major health benefits from each option (e.g. women, children, adult men), what the recurrent costs of each option will be, and what the manpower implications of each will be.

PHASE II: DISCUSSIONS WITH AFGHANS, DONORS, AND NGOs (1 month)

The objective of this phase is to sensitize and inform Afghans, donors, and NGOs about the long-term recurrent cost issues and their implications for health planning. The data and options developed during Phase I will be used to highlight the effects of various options on potential health impact as well as long-term recurrent cost implications of each option. These discussions may be informal or take place in organized workshops. Exact plans will be determined during Phase I.

PHASE III: HEALTH PLAN DEVELOPMENT (6-8 months)

The objective of this phase is to develop specific health plans, including regional plans wherever possible. This phase will include two major components: development of sustainable health plans and costing of capital and other nonrecurrent requirements to support these plans.

Component 1: Development of Sustainable Health Plans

The objective of this component is to develop health plans on a regional/area/tribal basis as appropriate. These plans should follow the principles discussed earlier and will include the number, type and location of health facilities, manpower needs, concrete implementation plans, and realistic recurrent cost budgets for each region/area and for the country as a whole. These plans will have targets for 3-5 years and, estimates of the recurrent costs of a "completed" system which might take ten or more years to implement.

Component 2: Costing of Capital and Other Non-Recurrent Requirements to Support the Plans

The objective of this component is to develop specific cost estimates for construction and maintenance of health facilities; for non-expendable equipment; and for other nonrecurrent development costs that donors may support (such as training costs). This may involve the development of architectural plans and specifications from which construction costs can be derived.

During the development of these plans and both recurrent and capital costing requirements, discussions will be held with various donor agencies who may wish to contribute to rebuilding and re-equipping the health sector in Afghanistan over the coming years.

Responsibilities for Overall Implementation of the Health Planning Process

MSH proposes that all of these phases leading towards a rational health delivery system for a postwar Afghanistan be conducted in a collaborative fashion utilizing the talents of everyone concerned -- Afghans, donors and NGOs alike. MSH staff will organize the data-gathering in Phase I and the development of a flexible computer-based spreadsheet model that can suggest recurrent cost implications of different allocation options. A detailed implementation plan for this phase is found later in this paper. MSH will also organize Phase II which may be done through workshops or on a more informal basis with Afghans, donors, and NGOs. Phase III will be done with the Alliance Health Committee, regional institutions, and other organized Afghan entities. The involvement of the donors and NGOs will be encouraged but the decisions will be made by the Afghans themselves.

III. OBJECTIVES OF PHASE I

There are three main objectives to phase I of the Health Sector Planning.

A. To collect and analyze data on demographics, epidemiology, and the recurrent costs of hospitals and the primary health care sector in Afghanistan.

B. To develop a framework which will facilitate the process of making decisions on how to allocate resources for health systems development in Afghanistan.

C. To develop options for the delivery of hospital and primary health care services based on population and epidemiological data and to project the future recurrent hospital,primary health care and vertical program costs and revenues under alternative infrastructure arrangements of each option at the regional and national levels in Afghanistan.

IV. MAJOR OUTPUT OF PHASE I

The major output of the study will be a document which will present alternative health infrastructure options for Afghanistan with accompanying revenue and cost data for each option. This information then can be used to facilitate discussions between the donor community, the Afghans and the NGOs as they make decisions about how to allocate resources to insure that both appropriate and sustainable health services are established in the country.

Supporting this document will be three analytical papers. One will be an analysis of the primary health sector including projected service needs of the population on a regional basis where possible, an inventory of current facilities, estimated recurrent costs of services under three to five different infrastructure options that would meet that population service needs,and an estimation of possible revenues from fee for service income in the long-term. A second paper will provide similar information for the hospital sector,with emphasis being placed on recurrent costs of different hospital sizes and service delivery capacities. A final paper will be prepared analyzing the need for vertical programs, such as malaria and immunization with accompanying projected recurrent cost data for different coverage targets. Drug and medical supply costs will be included in each of these papers.

V. IMPLEMENTATION PLAN: PHASE I

A. Methodology

The overall approach to developing alternative health infrastructure options for Afghanistan on a regional basis will be to collect demographic and health system data and to develop a framework to facilitate decision-making by Afghans, donors and the NGO community. The steps that MSH proposes to carry out are as follows:

1. Collect data in Pakistan

A field team consisting of a primary health care planner, a financial analyst and a hospital planner will collect information in Pakistan which will be critical to developing realistic health system options. Specifically they will collect data on: the demographics and current distribution of the population in Afghanistan and potential distribution after resettlement; the prewar and current estimates of the epidemiology of diseases in specific regions; the current consumption patterns for health services in Afghanistan and in refugee programs;the location and types of primary health care and hospital facilities that currently exist in Afghanistan;prewar and current Kabul government health service system costs and cross-border program service cost data. The information will be collected from a variety of sources including prewar population, epidemiological and service cost reports, current greenbook service data from cross border assistance programs,interviews with health workers who rotate into Pakistan for training and supplies and other UN,WHO and NGO reports which may give some indication of the population and health status of the Afghan population.

2. Prepare current inventory of programs and health care facilities in Afghanistan.

As part of the field work, the team will collate the data collected and prepare inventories of the location and to the extent possible, the condition of primary health care and hospital facilities by region. An inventory of the number and types of existing health care personnel also will be prepared. Similarly, an attempt will be made to determine where vertical programs, such as immunization,are functioning. These inventories,together with the demographic and epidemiological data by region will create a " health system map" of the country and will highlight gaps between need and services in Afghanistan. This map will serve as a baseline for discussions on where and in what order to locate new facilities and services.

3. Prepare Analytical Papers on Primary Health Care, Hospitals and Vertical Programs.

As a final phase of the field work, the team will begin preparation of papers analyzing the three major components of the health delivery system:Primary Health Care Services, Hospital Services and Vertical Programs. For each component,the paper will outline the major health problems of the population that need to be addressed, an inventory of existing facilities and personnel, an estimate of recurrent costs of services under several infrastructure options that could reasonably be

expected to meet the population service needs and an estimation of possible revenues from fee for service income or other sources in the long-term. Drug and medical supply costs will be included in each of the three papers. These analyses will provide baseline information for determining what segments of the population will receive benefits under various health services options and the recurrent cost and sustainability implications of each option.

It is estimated that the field work for steps one, two and three will take approximately 3-4 weeks of work each for the hospital planner and financial analyst and 1-2 weeks for the primary health care planner. Detailed Scopes of Work appear in section III.C.

4. Development of Framework for Decision-making

The data and analysis carried out in steps 1-3 will serve as baseline information against which decisions on resource allocation for developing health services in Afghanistan can be made. To assist in making the best decisions possible among a variety of options and within differing political climates, MSH believes that it is important to develop a framework which will allow the Afghans, donors and NGOs to understand the health benefit and sustainability implications of different options. The framework, or planning model, will be flexible enough to allow consideration of a wide range of resource allocation options;it should incorporate sufficient cost and revenue information to enable a number of alternative combinations of primary health care, hospital and vertical program options for given regions to be assessed in terms of feasibility, efficiency and sustainability.

In practice, if the framework is indeed to be both comprehensive and flexible, a micro-computer-based model is indicated. Such a model will include: relevant epidemiologic and population data, to determine the distribution of service requirements; personnel and other resource requirements of a "standard" delivery system tailored to the Afghan setting; unit cost projections and cost behavior relationships (fixed/variable/recurrent) for the elements of this standard system; and, other policy assumptions and decisions, which can be established as parameters in the model, and easily varied across the different options to be considered.

The creation of this model will result in the availability of a tool to not only support the preparation of the initial alternative options document at the end of phase I, but more importantly will be critical to the ongoing process of strategic, technical and financial decision-making that will occur among the Afghans, donors and NGOs during Phases II and III. As other options are developed and discussed by the decision-makers, this planning framework will allow them to rapidly see the potential health benefits and recurrent cost and sustainability implications of their decisions in comparison to other alternatives.

The development of the Framework for Decision-making will begin during the field work in Pakistan; it will be refined in Boston when all the component analysis papers are completed.

5. Production of the Initial Document Describing Several Alternatives for a Health System

When the three analysis papers are completed they will have described several infrastructure configurations that might be considered to provide different amounts and types of health benefits at differing recurrent costs to meet the health service delivery needs in the primary health care, hospital and vertical program components on a regional basis. With the assistance of the micro-computerized framework for decision-making, these options in each of the components can be combined to produce a variety of options that can be considered for the whole health system infrastructure in a given region or the country as a whole. Using the criteria of achieving maximum coverage, keeping recurrent costs as low as possible and considering long-term sustainability of services, MSH will produce a document which selects three to five health system infrastructure options which should be considered in initial discussion between Afghans, donors and NGOs. These options will be written up in a document which clearly describes the numbers and types of facilities and personnel by region, the expected health benefits that will result and the projected recurrent costs as well as an estimate of long-term financial sustainability of each option.

It is expected that this document will be finalized approximately six weeks after the field work has been completed.

V. B. WORK PLAN

Activities	Staff	Month 1				Month 2				Month 3			
		Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4
1. Collect data in Pakistan													
-Epidemiological	Solter												
-Populations/Demographics	Stinson												
-PHC system costs	Stinson												
-Hospital system costs	Blakner												
-Vertical program costs	Solter												
2. Prepare inventory of existing:													
-PHC facilities	Stinson												
-Hospital facilities	Blakner												
-Vertical programs	Solter												
-Health care personnel	Stinson												
3. Prepare analytical papers													
-PHC	Stinson												
-Hospitals	Blakner												
-Vertical programs	Solter												
4. Develop framework for decision-making	Team												
5. Produce alternatives document	Team												

MANAGEMENT SCIENCES FOR HEALTH
A NONPROFIT INSTITUTION

PLANNING SUSTAINABLE HEALTH
SERVICES IN AFGHANISTAN

February 10, 1989

165 ALLANDALE ROAD, BOSTON, MASSACHUSETTS 02130
CABLE: MANSHEALTH (617) 524-7799

PLANNING SUSTAINABLE HEALTH SERVICES IN AFGHANISTAN

February 10, 1989

Management Sciences for Health
Boston Staff

TABLE OF CONTENTS